Patient Information

Palmetto Health USC
MEDICAL GROUP

Patient Label

Patient's Name (last, first, middle) _____

SSN _____ Birth Date _____ Gender _____ Marital Status _____

Address _____

City/State/Zip _____

Phone: Home _____ Cell _____ Work _____

Email _____

Employer _____

Race and Ethnicity _____ Primary Language _____

Do you have a Healthcare Power of Attorney? ☐ Yes ☐ No Are you an Organ Donor? ☐ Yes ☐ No

Emergency Contact Information

Name _____

Relationship to Patient _____ Phone _____

Guarantor's (Financially Responsible Party) Information

☐ **Check if patient is guarantor**

Name _____ SSN _____ Birth Date _____

Address _____ City/State/Zip _____

Phone _____ Relationship to Patient _____

Insured's Information

Primary Insurance Company _____ Secondary Insurance Company _____

Insurance ID _____ Insurance ID _____

Group ID _____ Group ID _____

Name _____ Name _____

SSN _____ Birth Date _____ SSN _____ Birth Date _____

Phone _____ Phone _____

Relationship to Patient _____ Relationship to Patient _____

Release of Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physicians.

_____ _____

Patient's Signature or Legally Qualified Representative Date/Time

_____ _____

Patient/Guardian Print Name Relation to Patient

_____ _____

Palmetto Health-USC Medical Group Representative Date/Time